eHealth Care Quality and Patient Safety Board
Workgroup Assumptions and Recommendations

Assumption (asp.) / Recommendation (rec.)	**Technical requirements to achieve**	**Feasibility** (scale of 1-5; 5 being the least feasible)	**Timeframe** (scale of 1-5; 5 being the long term projects)	**Comments / Assumptions / Recommendations / Questions / Clarifications**
(Green shading indicates where clarification or questions remain.)				
CI WG* Rec 2.1: Priority consumer outcomes of HIE and HIT:				
▪ Information exchange that improves patient care	Pick an existing specification	1	3	Needs agreement of exchange information among entities with a common specification
	Current law needs to be carefully examined, and amended where appropriate	2	3-4	
	For information exchange that improves patient care (beyond post office concept), MPI required	3		
	RLS required for decentralized version			Significant integration challenges associated with getting data whether centralized or decentralized. Also some form of data integrity checking required.
▪ Appropriate consumer access to health information	Web portal	1	2	Possibility to encourage HIPAA covered entities to begin by providing portals to their EMRs beginning with claims data. More straightforward for electronic information already in electronic format (medications, immunizations, etc.). Use WIR model
	Consumer access requires authentication process	5	5	
	Consumer updates to health information require system supporting capability to distinguish between subjective and objective data	5	5	

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▪ Appropriate provider access to health information	Requires credentialing / authentication process	2	3	
▪ Security of health information	Pick a toolset	2	3	Emulate best practices in other industries, such as finance, for security.
	Appropriate security requires authentication process with safeguards (such as system lockout after repeated failed logins; and password change features);	3	3	
	Auditing process for determining whether EPHI access was appropriate	3	3	
▪ Decision support that ensures appropriate care	Decision support requires medication/allergy/lab data along with database (such as Micromedex) to support decision support querying process. Decision support also requires functionality for reducing "nuisance alters," in order to be effective.	4	4.5	Need agreement on clinical guidelines for both screening, treatment and health maintenance. Use WIR model. Decision support system value depends on multiple factors (if limited data is available, not very effective decision support). Even in data and functionality rich local environments, effective decision support requires customization per specialty and per provider to be effective, and this obviously raises the technical requirements.
CI & PC WG Rec 2.3: Highlight the following data elements in patient care list as elements of added privacy concern (in priority order):				Does this presume the existence of a patient locator service?

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▪ Identity/demographics/Master person index	Master person index	2	3	Both the master person index and the master provider index require some decision about architecture – how would this data be stored? Locally? Centrally statewide? Each healthcare organization already has a process for its own MPE. The key is just to link them together. Ideally the master person index would be stored at the highest level supported – i.e. nation would be my first choice, then state, then regional, then local.
	Provider index	1.5	1.75	Use the new NPI standard. This is also a critical component in my opinion. I think we're moving closer to this in other initiatives already underway with HIPAA.
▪ Diagnoses	Standards	1.67	1.67	If ICD9 dx is acceptable, use it from WHIO data. All diagnoses? All below assumes the existence of MPI, PI, and RLS (if decentralized); and depends on if real time or from claims data Chief complaint from ER registration information? Definitely need to encourage the use of a common definition of what is a "problem" versus a "diagnosis" as well as encourage the sue of standard nomenclature that sits on top of DRGs i.e. Snomed etc.

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▪ Medications	Standards	1.67	2	Intercept pharmacy claims at Pharmacy Benefit Manager level or health plan level. All medications? This would seem on the difficult side, given the route, frequency and other "sub' information required…
▪ Allergies	Standards	2	2	Usually collected only at health care provider level. There are many participants whose data would need to be captured to make this feasible. Or, instead think about relying on the patient for this information.
▪ Labs and Other Diagnostics	LOINC standard	2.33	3.33	Most labs are already electronic. There just needs to be a common standard and patient identifier to exchange results. All labs and diagnostics? May have an issue with reference ranges, so data means the same thing to the same providers There are many complex issues with shareing lab that are not technical in nature rather have to do with agreement on "what is a normal value" to one lab as compared to another based on how they configure their equipment.
▪ Procedures	Standards	1.67	2	Use WHIO, if possible. All procedures? CPT and DRG codes will assist here.
▪ Immunizations				

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▪ Patient visits and hospitalizations		2.25	2.5	Requires the participation of every physician entity and hospital entity to make his information available electronically. All patient visits and hospitalizations? Basic registration info or claims
▪ Discharge summaries and progress notes		3	4.67	Requires the participation of every physician entity and hospital entity to make his information available electronically. All? Many facilities are still writing these.
▪ Advance directives				See PC WG Asp 2.3.
▪ Payer/Insurance/Coverage and eligibility		2	1.25	Utilize and enforce the existing EDI standards required under HIPAA. Could come from payers… Should be easily obtained from facilities with systems in place.
▪ Medical devices				
PCWG[†] Asp 2.3: While the work group ranked advance directives relatively low in their ranking of priority data elements, the expectation is that it will be included eventually. Current hospital information systems tend to answer the question of advance directives availability only in a yes/no format which requires going to another location to get the actual content of the directive. The goal is to have advance directive information incorporated into the electronic patient summary accessible through a common portal.	State web portal for Personal Health Record	4	5	Lots of issues, including version control. Maybe the state would do well to provide the opportunity for individuals to post their Advance Directives on a state sponsored personal health record web portal that the patient controls, and could be made available to care givers.
	Hospital process must allow for routine collection and reporting of this information into the electronic patient summary.	2	2	

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	We need to have quick access to whether a patient wants CPR or not in addition to whether they have their advance directives completed and on available. Ideally the advance directives, would be in an electronic form, if not, then scanned and available for all to view.	2	4	Yes/No answers to advance directives and CPR should be top priority with the actual access to the advance directives close behind. Having worked on this ourselves, it's easier said than done. It's absolutely imperative that the yes/no answers be accurate so internal process must be tight.
CIWG Rec 3.1: In accordance with current Wisconsin law (providers *shall* share patient information for treatment purposes) patients will not be permitted to opt-out of including their general health information in Wisconsin's information exchange. Recommendations regarding the possibility of opting out of including more sensitive information are in progress (see charge #4 in the progress report).		3.33	3.33	The opt-out provision for sensitive health information is likely to be very difficult to administer accurately. Again, maybe this could be done via a state sponsored personal health record web portal Limiting opt-out ability reduces technical complexity. I stand in the middle of this because we do state "general information." Where we tend to see patients want to pull back is when their data contains behavioral health and sensitive lab value content. We strongly discourage patients from opting out of allowing their data to be shared across our organization. However, there are situations where we need to do that especially if the patient is at risk of harm by someone or something like that. WE only have a few in this status at any given time, and it's very difficult to manage from a process perspective. If the patient shows up in the ER and they are in a critical state, they loose their authority to opt out and we override the decision to access the information.

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				The patient understands that when they sign the documents for opting out at Gunderson Lutheran
CI WG Rec 3.2: Adopt Markle Foundation *Consumer and Patient Principles for System Design* as a template for recommendations related to access.		1	5	I think this entire concept is important and critical, but would like to see us focus and be successful on the basics before we advance to this phase
▪ Individuals should be able to access their health and medical data conveniently and affordably (#1)	Web portal	3.67	3.33	State sponsored web portal could make this available for every WI resident. The more and the better the data, the higher the cost, so convenience and affordability may work against each other.
▪ Individuals should be able to decide (i.e., authorize) when their health data are shared, and with whom (#2)		2	2	This suggests an opt-in/out strategy, which appears to be in conflict with CI WG Rec 3.1.
▪ Individuals should be able to designate someone else, such as a loved one, to have access to and exercise control over how their records are shared (#3)	Secure system with patient control over access.	3.67	3.67	Need a state sponsored web portal so each individual has only one place in which to register who may access and to what degree. May need to include an override for sensitive information, such as mental health… Patient control over access as opposed to access being governed by agreed upon security rules could raise technical requirements and costs significantly, depending on what is being proposed.
▪ Individuals should receive easily understood information about all the ways that their health data may be used or shared (#4)	Report mechanism	1.5	1.5	Similar to HIPAA Notice of Privacy Practice
	Audit function	2.33	3.33	Each entity with Protected Health Information would need to develop its own audit mechanism. I believe most organizations already do this with HIPAA.

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▪ Individuals should be able to review which entities have had access to their personal health data (#5)	Report mechanism	2.5	3.5	
	Audit function	3	3.33	
▪ Electronic health data exchanges must protect the integrity, security, privacy, and confidentiality of an individual's information (#6)	Secure system	3.67	3.33	Within certain boundaries, such as those described in HIPAA, this can be done.
CI WG Rec 4.1: Add the following areas to discussion of sensitive health information: ▪ Adoption ▪ Developmental disabilities ▪ Sexual assault ▪ Domestic violence	Sensitive health information tracking fields at the provider level.	2	5	Most existing Health Information Management systems are not set up to deal with a ll of these "sensitive" areas. I thought developmental disability are already considered sensitive information under 51.30(1)(b) Good – just want to focus on the basics and do theme well before we expand our scope.
CI WG Rec 4.3: Current controlling law (Wisconsin law or HIPAA) should serve as the foundation for treatment of sensitive information (i.e., whether or not patients can opt-out or opt-in).	Standards	1.5	1.5	Having single standard simplifies technical considerations.
CI WG Rec 4.4: Patients should be made aware of the risks and benefits of excluding their health information from exchange. **Key concerns identified in discussions to date:** ▪ What is included in exchange ▪ Who has access to the information exchanged ▪ A patient/consumer's ability to influence (or limit) access ▪ Whether an individual is receiving routine or emergency care	Opt-out	4	5	This suggests an opt-in/out strategy, which appears to be in conflict with CI WG Rec 3.1. Will require significant education initiatives.

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G WG Asp 1.4: Need very clear standards – and to wait to see what comes at a national level. Until this happens, HIT and HIE can not move quickly. In the meantime there is excellent work underway and don't want to slow it down.	Technology standards critical	3	3	Efforts nationally, but what can be done at the state level to help accomplish this.
F WG‡ Asp 1.6: The system requires re-engineering processes and workflow, and adoption phase-in will incur productivity costs.	Pick standards	3	5	Interoperability standards are necessary. This should be considered when deciding what to prioritize. Especially the issue of whether a given proposal may or may not make sense given optimal workflow needs in a provider organization.
F WG Asp 1.7: The system requires consistency of platforms and standards for inter-operability.	Technology standard critical.	2	3	At least regional, if not statewide. We need standards in the data exchange format not in the technology itself. The technology platform needs to remain non-proprietary.
F WG Asp 1.9: Must accommodate existing efforts and incorporate legacy systems. Avoid creating multiple login environments where HIT exists but interface capability is currently lacking.		3	3.67	DOQ-IT is getting there. Would require fully developed solution and support for facilities with data but no expertise to integrate. May only be feasible for integrated HIS users, where limited number of vendors (but high yield in terms of clinical HIT) would be engaged in the process (ON the hospital side: CPSI, Dairyland, HMS are primary vendors, at least in South Central). I agree completely, this is a large technology challenge and must be

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				managed well.
F WG Asp 1.12: HIE will allow for flexible flow of clinical data across systems and referral centers, rather than limiting access within existing referral relationships and proprietary networks.		3.5	3.5	Neutral exchange likely to facilitate flexible flow, rather than point to point.
F WG Asp 1.14: HIE functions most commonly pursued in the first two years are as follows: clinical messaging, medication reconciliation, PH outbreak surveillance, electronic referrals and authorizations, electronic signature, e-prescribing, P4P/quality data reporting, electronic billing support. (eHealth Initiative Toolkit)		3	2	Very broad focus here. Each item would need to be broken out and defined.

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Grey shading indicates that no technical requirements had been identified.

CI WG[§] Rec 2.1: Priority consumer outcomes of HIE and HIT:				
▪ Improved communication among parties relevant to patient care	No clear technology needs identified related to this item	2	4	Many healthcare organizations have their resources tied up with internal implementations and devote little time to dealing with external entities.
CI WG Rec 2.2: Add 'medical devices' to high priority EHR/HIE data elements identified by patient care group. Medical devices to include such items as hearing aids, pace makers, dentures, etc.	No clear technology needs identified related to this item	1.33	1.33	Need more concrete examples of medical devices. Some are more readily adaptable than others. Imaging studies, for example, are very ready for HIE. Need to do this especially with lab systems.
CI WG Rec 4.2: Discussions should differentiate between areas delineated by HIPAA (treatment, health care operations, payment, public health).	No clear technology needs identified related to this item	2	1.67	This needs to be done sooner than later – I agree.
G WG Asp 1.1:** Some kind of structure or group is needed to oversee coordination of all of these initiatives across the private and public sectors is needed	No clear technology needs identified related to this item	2	3	
G WG Asp. 1.2: At a minimum, need a coordinating body for information sharing and to support these initiatives and have work of substance to do	No clear technology needs identified related to this item	2	2	
G WG Asp 1.3: Some of the Wisconsin organizations are far ahead of what other states are trying to do and we need to start at this point and move forward o There is a lot of energy in some of these organizations o Some fit together better than others and some of things will happen at a different pace o WHIO Board is now creating	No clear technology needs identified related to this item	3	3	All organizations need to operation under current law or amend law.

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subcommittees to integrate new public reporting with existing public reporting underway in Wisconsin o WHIO is too new to take this on at this time - needs to focus on its core mission				
G WG Asp 1.5: One way to do this is to convene the leaders of key organizations to function as a leadership council with clear roles for coordination and communication	No clear technology needs identified related to this item			SN – A combination of leadership and technical savvy is necessary to get this going.
G WG Asp 1.6: There is a need for staff support for the enterprise	No clear technology needs identified related to this item			
G WG Asp 1.7: It is essential to have authority to move forward, to implement plans – and it may need to be established legally to seek funds. Need the legal responsibility to fulfill the mission.	No clear technology needs identified related to this item			
G WG Asp 1.8: The description of the Arizona and Minnesota models is helpful and makes sense – more information about current status of Minnesota effort is needed	No clear technology needs identified related to this item			
G WG Asp 1.9: An incremental process is anticipated as Minnesota has done	No clear technology needs identified related to this item	2	2	Need more information on MN process

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G WG Asp 1.10: The building block concept described in the AHIMA work book is helpful – once identify problems can then devote energy to addressing them. Don't need to have the whole thing figured out at the beginning - will need to be adaptable	No clear technology needs identified related to this item	2	5	
G WG Asp 1.11: This group needs to agree on the vision and understand why existing organizations can not carry the eHealth governance role	No clear technology needs identified related to this item	2	1	
G WG Asp 1.12: Leadership of WCHQ, WHIO, WHIE, WHA, other provider and consumer representatives would be the core membership	No clear technology needs identified related to this item	2	1	Agreed, although I would also include vendor representatives from Epic and GE Healthcare
G WG Asp 1.13: A small group is essential so existing initiatives are not slowed down– too big and there are many problems - can always expand as appropriate	No clear technology needs identified related to this item	2	1	
G WG Asp 1.14: This would be a strategic body with low operating costs – probably not research or grant funded and should not compete for funding with other current initiatives	No clear technology needs identified related to this item	2	1	
G WG Asp 1.15: There is real added value to convene leaders, align interests, build synergy about how these various initiatives can come together and to take ownership of the goals for health information exchange	No clear technology needs identified related to this item	2	1	

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G WG Asp 1.16: May not need to maintain the existing eHealth Board if a new structure is created – if maintain two organizations they would have to be closely linked so as not to be redundant and uncoordinated	No clear technology needs identified related to this item	2	1	
G WG Asp 1.17: A key issue for the future is funding	No clear technology needs identified related to this item			Agreed, but there should be long-term productivity benefits
F WG Asp 1.8: Approach must be statewide, politically feasible, consistent with federal initiatives.	No clear technology needs identified related to this item	2.5	3	Agree. Does not make sense to develop state standards in advance of national efforts.
F WG Asp 1.10: Low volume - particularly low volume unaffiliated – organizations may need help implementing EHR systems.	No clear technology needs identified related to this item	3	4	

[*] CI WG = Consumer Interests Workgroup
[†] PC WG = Patient Care Workgroup
[‡] F WG = Financing Workgroup
[§] CI WG = Consumer Interests Workgroup
[**] G WG = Governance Workgroup